Prescription Drug Claim Form

WELLPOINT nextRx

Important: Please read the instructions sheet carefully prior to completing this form.

A. - Cardholder / Patient Information

Cardholder's Last Name, First Name Middle Initial	Plan Name	Cardholder ID Number	Today's Date
	040		

Address	City	State	ZIP

Why was the insurance or drug card NOT used for this purchase? Explain below.

Employer Name	Group Number

Patient's Last Name, First Name Middle Initial	Patient's Date of Birth	Patient's Gender
		☐ Male ☐ Female

Patient's Relationship to Cardholder

☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Is the patient eligible for Medicare, Part D (prescription drug) coverage?

☐ No ☐ Yes

B. - Other Insurance Coverage

Is the patient eligible for primary prescription drug coverage from another provider

☐ No ☐ Yes If Yes, Please use other insurance card to complete the fields below.

Insured's Last Name	First Name	Middle Initial

Other Insurance Company's Name	Member ID	PCN	Other Coverage's Effective Date

Other Insurance Company's Address	City	State	ZIP

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to WellPoint NextRx, its agents or representatives.

Signature _____ Date _____

Insurance Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.

C. - Claim Information
(Completed by pharmacist/physician)

Complete all sections or attach the *original* pharmacy prescription receipt. Receipt copies will not be accepted.

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
1.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
2.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
3.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
4.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
5.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx?
6.				**If 'yes', please attach a compound claim form.**

Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage

Charge (including tax)	Other Charges/Fees (including tax)	Prescriber Name	Prescriber ID

D. - Authorization (Completed by pharmacist / physician)

Pharmacy / Physician Name	Address	City	State	ZIP

Pharmacist / Physician Signature

_____

Note: Payment for the above claims(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of WellPoint NextRx.

If more than six prescriptions, please fill out additional claim forms.

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INSTRUCTIONS

Cardholder

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased due to an emergency or at a non-participating pharmacy.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items in the section A for both cardholder and patient.
4. Sign the form in the area provided.
5. Include the ORIGINAL prescription receipt with this form and make copies for your records. Copies of the receipt will not be accepted for reimbursement.
6. Have your pharmacist complete sections B and C on the form.
7. For a list of participating pharmacies in your area, please refer to your member kit materials or call the customer service number on the back of your ID card.
8. Mail completed form to **WellPoint NextRx - PO Box 4165 - Woodland Hills, CA 91365-4165**

Pharmacist:

1. Complete all items in sections (B) and (C) of the form. Complete section (D) if needed.
2. Use a separate form for each patient.
3. Be sure to sign the form in the area provided.

If you have any questions, please call your Customer Service area.

English: If you need assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID card or in your enrollment booklet.

Spanish: Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Korean: 당신이 이 문서를 이해하는 원조를 필요로 하는 경우에는, 당신은 당신의 I.D 카드의 또는 당신의 병적편입 소책자에서 뒤에 소비자 봉사 수를 불러서 그것을 추가 비용 없이 요구할지도 모른다.

Chinese: 如果你需要帮助了解这个文件你 可以要求在不增加额外费用的客户服务电话号码或身分证背面你 贵招生简介.